Encounter Keys

AHCCCS

Jan-Feb. 2009

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FFS Rate Change

Effective February 1, 2009 the FFS program is reducing the FFS rates by 5 % for provider's, with some exceptions as outlined in the public notice posted on the AHCCCS Website. As communicated to executive plan staff these rate reductions exclude plan (MCO) payments and are limited to AHCCCS FFS claims payments only, with the exception of CMDP.

As a result two new reference tables (RF132 and RF142) and a new FTP reference file (Reference 05 - REFER05.ZIP) have been added, which will include the appropriate rate schedules prior to the 5% reductions. The Reference 05 file will contain these rates, which the Health Plans must utilize as the basis for their non-contracted rates, and plans should no longer utilize the FFS rate schedule FTP reference files (Reference 02 - REFER02.ZIP and Reference 03 - REFER03.ZIP) for loading and/or considerations in their claims payments.

The Reference 05 record layout is attached. The Encounter Manual will also be revised to include the Reference 05 record layout.

Also, as a result, some rates which sit on the provider sub-system table (PR050), because they are provider-specific and/or provider-type-specific, are also impacted. For these impacted rates for provider types: 41 - freestanding dialysis, 71 - psychiatric hospital, 97 – Air Transportation, B1 - RTC secure 17+beds, B2 - RTC non-secure 1-16beds, B3 - RTC non-secure 17+beds, B5 - Sub acute 1-16beds, B6 - Sub acute 17+beds, 77 – BH Clinic, and 78 - MH RTC, AHCCCS has added new rate schedule types (whose rates will equal the January 31, 2009 rates) that must be utilized as appropriate by health plans (except CMDP) for dates of service on or after 2/1/2009 The following chart outlines the specific usage for each rate schedule type:

FFS and MCO's - Dates of service prior to 2/1/2009	**FFS and CMDP - Dates of service on or after 2/1/2009**	**MCO's - Dates of service on or after 2/1/2009**
Provider Type 97:	*Provider Type 97:*	*Provider Type 97:*
PST (Posted Charges)	PST (Posted Charges)	PTC (Posted Charges - MCO Rate)
Provider Types 41, 71, B1, B2, B3, B5, B6, 77 and 78	*Provider Types 41, 71, B1, B2, B3, B5, B6, 77 and 78*	*Provider Types 41, 71, B1, B2, B3, B5, B6, 77 and 78*
PDM (Per Diem)	PDM (Per Diem)	PDC (Per Diem - MCO Rate)
Provider Type 41	*Provider Type 41*	*Provider Type 41*
TRN (Training)	TRN (Training)	TRC (Training - MCO Rate)

Rates & New Codes

Effective January 1, 2009 new codes and rates for the Physician Fee Schedule can be found on the AHCCCS website: http://www.azahcccs.gov/RatesCodes/Default.aspx

Out Patient Fee Schedule (OPFS) Facility Peer Groups can be found on the AHCCCS website: http://www.azahcccs.gov/RatesCodes/Default.aspx

PHYSICIAN FEE SCHEDULE RATE CHANGE CPT 80047

Effective for dates of service on and after 01/01/2009, the AHCCCS Physician Fee Schedule rate for CPT 80047 will be $12.36. This change is made consistent with the Medicare 2009 Clinical Laboratory Schedule. Questions concerning the AHCCCS FFS Physician Fee Schedule may be directed to Victoria Burns at (602) 417-4049, or if outside Maricopa County (800) 654-8713 ext. 7-4049

New Hospital(s) and Changes to Existing Hospital(s)

- Arizona Regional Medical Center is a new hospital with an official CMS effective date of service beginning 10/30/2008. For further information regarding this facility, please contact Cynthia C. Barker CPC at 602-417-4708 or fax 602-417-4725.

- There are two new rate sheets for Gilbert Hospital. Gilbert Hospital has added ICU services as of 8/25/2008. The rate sheets cover the period from 8/25/2008-9/30/2008 and 10/1/2008-9/30/2009. Information can be found on the AHCCCS website: http://www.azahcccs.gov/RatesCodes/Default.aspx

Hemophilia Update

1st Quarter 2009 pricing schedule for Hemophilia products effective from 1/1/2009 through 3/31/2009 have been posted on the AHCCCS website: http://www.azahcccs.gov/RatesCodes/Default.aspx

Updates to the OPFS Facility Peer Groups Document are attached. As a correction to an earlier communication regarding White Mountain Regional Medical Centers change from a Small Rural hospital to a Critical Access Hospital, please note the revised effective date of 8/26/2008

Coverage Code(s)

- Effective for dates of service on or after January 1, 2008 the AHCCCS Coverage Code has been changed to 09 (Medicare Only) for the following codes:
    - G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes)
    - G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes)
- Effective for dates of service March 1, 2009 the CPT code 90882 (Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions) will have an AHCCCS coverage code of 04 (Not Covered Service/Code Not Available).
- Effective for dates of service on or after January 1, 2006 the CPT Code 92508 (Treatment of Speech, Language, Voice, Communication, And/Or Auditory Processing Disorder; Group, 2 Or More Individuals) has an AHCCCS Coverage Code of 01 (Covered Service/Code Available).

Code Updates

Effective with different dates of service, the codes listed below have an AHCCCS Coverage Code of 01 (Covered Service/Code Available), and may have procedure daily maximum updates.

CODE	DESCRIPTION	EFFECTIVE BEGIN AND/ OR END DATE	PROCEDURE CODE INDICATORS AND VALUES (RF113)
0090T	Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace (other than for decompression), cervical; single interspace	7/1/08-12/31/08	No Change
0092T	each additional interspace (List separately in addition to code for primary procedure	7/1/2008	5
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	7/1/2008	5
0096T	Revision of total disc arthroplasty, anterior approach cervical; single interspace	7/1/08-12/31/08	No Change
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	7/1/2008	5
0163T	Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace(other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	7/1/2008	4
22856	Total disc arthroplasty (artificial disc), anterior approach including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical	1/1/2009	1
22857	Total disc arthroplasty (artificial disc), anterior approach including discectomy to prepare interspace(other than for decompression), single interspace, lumbar	7/1/2008	1
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	1/1/2009	1
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	7/1/2008	1
88305	Level IV - Surgical Pathology, Gross and Microscopic Examination	1/8/2009	15
88361	Morphometric analysis, tumor immunohistochemistry (eg, HER-2/ NEU, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology	1/8/2009	5
90767	Intravenous Infusion, For Therapy, Prophylaxis, Or Diagnosis (Specify Substance Or Drug); Additional Sequential Infusion, Up To 1 Hour (List Separately In Addition To Code For Primary Procedure)	12/18/2008	1
96411	Chemotherapy Administration; Intravenous, Push Technique, Each Additional Substance/Drug (List Separately In Addition To Code For Primary Procedure)	12/18/2008	5

Place of Service (POS)

- Effective for dates of service on or after January 1, 2006 the following CPT codes have been added to the POS 23 (Emergency Room – Hospital) and 24 (Ambulatory Surgical Center):
    - 90772 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular))
    - 90775 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure))
- Effective for dates of service on or after June 1, 2008 the POS 12 (Home) has been added to the HCPCS code E1815 (Dynamic Adjustable Ankle Extension/Flexion Device, Includes Soft Interface Material)
- Effective for dates of service on or after January 1, 2008 the HCPCS Code L8680 (Implantable Neurostimulator Electrode, Each) can be reported at Place of Service 11 (Office).
- Effective for dates of service on or after January 1, 2007 the Place of Service 81 (Independent Laboratory) has been added to the CPT 87209 (Smear, primary source with interpretation; complex special stain (eg, Trichrome, Iron Hemotoxylin) for ova and parasites).
- Effective for dates of service on or after January 1, 2006 the following CPT codes have been added to the POS 23 (Emergency Room – Hospital) and 24 (Ambulatory Surgical Center):
    - 90772 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular))
    - 90775 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure))
- Effective for dates of service on or after January 1, 2008 the POS 71 (State Or Local Public Health Clinic) has been added to the CPT code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure).

Medicare Indicator Change(s)

Effective for dates of service on or after January 1, 2009 the Medicare Indicator found on PMMIS screen(s) RF113 and RF127 has been changed to N (Not a Medicare covered service).

Code	Description
C9358	Dermal Substitute, Native, Non-Denatured Collagen (Surgimend Collagen Matrix), Per 0.5 Square Centimeters
Q4100	Skin Substitute, Not Otherwise Specified
Q4103	Skin Substitute, Oasis Burn Matrix, Per Square Centimeter
Q4104	Skin Substitute, Integra Bilayer Matrix Wound Dressing (BMWD), Per Square Centimeter
Q4105	Skin Substitute, Integra Dermal Regeneration Template (DRT), Per Square Centimeter
Q4107	Skin Substitute, Graftjacket, Per Square Centimeter
Q4108	Skin Substitute, Integra Matrix, Per Square Centimeter
Q4109	Skin Substitute, Tissuemend, Per Square Centimeter
Q4110	Skin Substitute, Primatrix, Per Square Centimeter
Q4111	Skin Substitute, Gammagraft, Per Square Centimeter
Q4112	Allograft, Cymetra, Injectable, 1cc
Q4113	Allograft, Graftjacket Express, Injectable, 1cc
Q4114	Integra Flowable Wound Matrix, Injectable, 1cc

Effective for dates of service on or after January 7, 2009 the following codes now have a Medicare Coverage of "N" (N means Medicare does not cover it).

22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels (list separately in addition to code for primary procedure)
0062T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level
0063T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (list separately in addition to 0062T for primary procedure)

Provider Type (PT)

Procedure Code	Description	Provider Type	Effective Date
G0008	Administration of Influenza Virus Vaccine	08 MD-Physician	10/01/2008
G0154	Services Of Skilled Nurse In Home Health Setting, Each 15 Minutes	23 Home Health Agency	01/01/2006
Q9965	Low Osmolar Contrast Material, 100-199 Mg/Ml Iodine Concentration, Per Ml	04 Laboratory	01/01/2008
Q9966	Low Osmolar Contrast Material, 200-299 Mg/Ml Iodine Concentration, Per Ml	04 Laboratory	01/01/2008
Q9967	Low Osmolar Contrast Material, 300-399 Mg/Ml Iodine Concentration, Per Ml	04 Laboratory	01/01/2008
27788	Closed Treatment Of Distal Fibular Fracture (Lateral Malleolus); With Manipulation	10 Podiatrist	01/01/1997
29540	Strapping; ankle and/or foot	14 Physical Therapist	01/01/2008
90696	Diphtheria, Tetanus Toxoids, Acellular Pertussis Vaccine and Poliovirus Vaccine, Inactivated (DTAP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	08 MD-Physician, 18 Physicians Assistant, and 03 DO-Physicain Osteopath	10/01/2008
99601	Home Infusion/Specialty Drug Administration, Per Visit (Up To 2 Hours)	03 Pharmacy	01/01/2007
99602	Home Infusion/Specialty Drug Administration, Per Visit (Up To 2 Hours); Each Additional Hour (List Separately In Addition To Code For Primary Procedure)	03 Pharmacy	01/01/2007
92630	Auditory Rehabilitation; Prelingual Hearing Loss	15 Speech/Hearing Therapist	01/01/2006
92633	Auditory Rehabilitation; Postlingual Hearing Loss	15 Speech/Hearing Therapist	01/01/2006
97014	Application Of A Modality To One Or More Areas; Electrical Stimulation (Unattended)	16 Chiropractor	01/01/1997
99368	Medical Team Conference With Interdisciplinary Team Of Health Care Professionals, Patient And/Or Family Not Present, 30 Minutes Or More; Participation By Nonphysician Qualified Health Care Professional	14 Physical Therapist and 15 Speech/Hearing Therapist	01/01/2008

Sex Indicator

The gender edit "F" female has been removed for the Diagnosis code 599.72 (Microscopic Hematuria).

Age & Limit Change(s)

- Effective for dates of service on or after December 2, 2008 the maximum age has been changed to **2 years** for the HCPCS code L1620 (HO, abduction control of hip joints, flexible, (Pavlik harness), prefabricated, includes fitting and adjustment)) and the frequency limit has been changed to 3 months.

Category of Service (COS)

Effective for dates of service on or after April 1, 2003 the HCPCS code C1814 (Retinal Tamponade Device, Silicone Oil) is now associated to Category of Service 40 (Medical Supplies).

Revenue Code

- Effective for dates of service on or after October 1, 2008 the Revenue Code 0921 (Perivascular Lab) has been added to the CPT code 93721 (Plethysmography, Total Body; Tracing Only, Without Interpretation and Report).

RF773 Updates

Effective for dates of service on or after October 1, 2008 changes to the PMMIS Reference screen RF773 have been updated. **Note:** Add means it has been added to that specific Revenue Code and Close means the procedure code has been end dated for that specific Revenue Code effective date September 30, 2008.

- Effective for date of service on or after October 1, 2008, the HCPCS code A4690 (Dialyzer (Artificial Kidneys), All Types, All Sizes, For Hemodialysis, Each) has been added to the revenue code 0272 (Sterile Supply) on PMMIS screen RF773.

- Effective for date of service on or after October 1, 2008, the CPT code 97602 (Removal of Devitalized Tissue From Wound(s), Non-Selective Debridement, Without Anesthesia (eg, Wet-To-Moist Dressings, Enzymatic, Abrasion), Including Topical Application(s), Wound Assessment, And Instruction(s) For Ongoing Care, Per Session) has been added to the revenue code(s) on PMMIS screen RF773.

0450	Emergency Room
0510	Clinic
0519	Other Clinic
0520	Freestand Clinic
0529	Other Fr/Std Clinic
0761	Treatment Room
0940	Other RX SVS

RF729 Updates

- CPT Code 90281 (Immune globulin (IG), human, for intramuscular use) has been end dated with an effective date of December 31, 2008 see PMMIS reference screen RF729.

- CPT Code 90650 (Human Papilloma Virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use) has been removed from the PMMIS reference screen RF729.

Modifier(s)

- Effective for dates of service on or after January 1, 2008 the modifier GW (Services not related to hospice patient's terminal care) has been added to the following codes on Reference Screen 122 (Valid Procedure Modifiers)

- Effective for dates of service on or after January 1, 2006 the CPT Code 90649 (Human Papilloma Virus (HPV) Vaccine, Types 6, 11, 16, 18 (Quadrivalent), 3 Dose Schedule, For Intramuscular Use) can report the modifier Q6 (Locum Tenens).

- Effective for dates of service on or after January 1, 2008 the modifier SL (State Supplied Vaccine) has been added to the CPT code 90681 (Rotavirus Vaccine, Human, Attenuated, 2 Dose Schedule, Live, For Oral Use).

- Effective for dates of service on or after January 1, 2009 the modifier QW (CLIA Waived Test) has been added to the CPT Code 87905 (Infectious agent enzymatic activity other than virus (eg, Sialidase activity in vaginal fluid)).

Procedure Code	Procedure Code Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity

99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity
99241	Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making
99242	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making
99243	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity
99244	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity
99245	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity

Table Updates

Several reference tables recently were updated to reflect a one-to-one code crosswalk. For example, physician and physician extender provider types have been updated on RF618; revenue code to bill types on RF773; and revenue codes to procedure codes on RF774. In addition, procedure/place of service combinations on RF115 and procedure/modifier combinations on RF122 and RF121 are also undergoing review and revision. If you have encounter pends which you believe are in error, due to a missed code update, please forward the missed code groupings to the Encounter Unit for review.

Replacement and Void Reminder

AHCCCS previously distributed emails in June, October, and November 2008 regarding replacements and voids. Please note that in December 2008 AHCCCS disabled encounter logic that replaces or voids encounter data at the line. AHCCCS only accepts professional (837P) and dental (837D) replacements or voids at the header, which replaces or voids all previously submitted lines associated with the first 12 digits of the CRN. When replacing or voiding at the header only the first 12 digits of the CRN should be submitted. For replacements the encounter must reflect the plan's final disposition of all claim lines.

Encounter Statistical Comparisons

The Encounter Unit has developed process statistical measures for the adjudication system to use for plan comparisons. Plans are placed into an Acute or ALTCS peer group. Means, variances, and standard deviations are calculated based on the peer group and the plan utilizing paid member months. Below are the targets, outlier data excluded, most plans should reach quarterly, if not monthly.

- **Acute Plan Peer Group based on 3 years of data**

  New Day Encounter Submissions - at least 1.75 encounters per paid member month
  Total Encounters Approved/Finalized - at least 2.86 encounters per paid member month
  New Day Encounter Submissions that resulted in a pend - no more than 0.30 encounters per paid member month
  Total Encounters Pended - no more than 0.81 encounters per paid member month
  Total Encounters Approved/Finalized by month of service (refer to Encounter Submission Tracking Report (ESTR) report in the Encounter Manual) - at least 2.45 encounters per paid member month within 8 months of service.

- **ALTCS Peer Group based on 3 years of data**

  New Day Encounter Submissions - at least 11.06 encounters per paid member month
  Total Encounters Approved/Finalized - at least 12.34 encounters per paid member month
  New Day Encounter Submissions that resulted in a pend - no more than 1.40 encounters per paid member month
  Total Encounters Pended - no more than 2.81 encounters per paid member month
  Total Encounters Approved/Finalized by month of service (refer to ESTR report in Encounter Manual) - at least 12.28 encounters per paid member month within 8 months of service.

Edit Change(s)

Edit description change has been made to the following edits in the Production and Test regions for A900 and A901.

- **Edit A900 UNREASONABLE HEALTH PLAN PAID AMOUNT**

  From: Unreasonable Health Plan Paid Amount (50%)
  To: Unreasonable Health Plan Paid Amount

- **Edit A901 UNREASONABLE HEALTH PLAN PAID AMOUNT**
  From: A901 Unreasonable Health Plan Paid Amount (25%)
  To: A901 Unreasonable Health Plan Paid Amount

- **P332 - Group Billers Not Allowed As Service Providers - Resubmit With Service Provider**

  Mode: 1
  Form Types: I/P, O/P, LTC, A, C, D
  Set to Pend "Y"
  Adjudication level: 80
  Location: 91
  DOS: 07/01/2005

  Mode: 2 & 6
  Form Types: I/P, O/P, LTC, A, C, D

- **Z645 - Near Dup Found-Provider Not Matched, Dates Overlap, Different Plans**

The following edit has been placed on the batch override table for the health plans to override.
Edit Z645 - Near Dup Found-Provider Not Matched, Dates Overlap, Different Plans
Form types: I/P & LTC